MEDICAL DISCIPLINE AND LICENSING IN THE STATE OF NEW YORK: A CRITICAL REVIEW

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HISTORICAL BACKGROUND

MEDICAL DISCIPLINARY and licensing measures protect the public from substandard practice by physicians and physicians' assistants. Over the past 300 years the methods to deal with these issues have varied but their objectives have remained the same.

Regulation of the medical profession in this state has a long history. In 1684 practice privilege was denied "without the advice and consent of such as are skillful on the said Arts."[1] A 1760 law provided that in New York City the examination and licensing of candidates be by specified magistrates. There then were no medical schools in this country, and would-be physicians were apprenticed to practicing physicians, the rule until very late in the 19th century. An 1806 law permitted legally constituted county and state medical societies to examine and to license candidates, but the State Medical Society could countermand any licensing decision by county societies. In 1809 the Board of Regents, as part of the University of the State of New York, was charged with the incorporation of colleges and the empowering of such colleges to grant medical degrees. A medical degree carried with it the license to practice. The same law also enabled incorporated colleges to endorse degrees conferred by colleges outside the state, provided that approval of the Regents was obtained.

During the following 70 years a struggle to control the licensing power was waged by the organized medical profession, medical colleges, and the University of the State of New York through the Board of Regents. In 1806 the penalty for practising without a license was the denial of the right to sue to collect fees! In 1813 all such penalties were abolished, but in 1827 county

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medical societies were empowered to regulate the licensing of physicians and to expel members from said societies for "gross ignorance or misconduct in his profession or immoral conduct or habits."[1] Practice was limited to those certified by the medical society and to those whose M.D. degree had been granted by a university. In 1880 the medical societies were denied their role in licensing, and this authority was assigned to the Board of Regents and to the colleges. In 1890 the Board of Regents became the sole licensing agency, and was further authorized to endorse the medical courses in respective colleges. A Board of Medical Examiners was created with representatives from the medical profession, including homeopathic and eclectic schools, to examine and license candidates.

The New York Academy of Medicine was founded in January 1847 and one of its stated objectives was "the separation of the regular from the irregular practitioners."[2] Quackery and sectarianism were rampant at the time. Continuing medical education was discussed in the December 1878 Anniversary Address by Dr. W.H. Thomson: "There are but few physicians of 15 or 20 years' experience in practice who would not be glad to take advantage of a law or custom which would oblige the whole medical fraternity to go back, once every ten years, to their educational institutions and take an entirely new course in all branches, not excepting the most elementary ones...."[3]

In 1926 and 1927 the Academy was involved in changing state laws relating to licensure and discipline.[4] The Medical Practice Act removed investigation and discipline from the overburdened Board of Medical Examiners, and vested them in the Department of Education's Board of Regents. Not until 1975 was the physician disciplinary process transferred to the Department of Health and its new Board for Professional Medical Conduct and Office of Professional Medical Conduct. However, except for appeal to the courts, final disciplinary action remained with the Board of Regents.

During succeeding years the Academy, through its Committee on Medicine in Society, continued its involvement in the functioning and the membership of the Board for and Office of Professional Medical Conduct. It soon became clear that the new agency was grossly underfunded and understaffed. The Academy pressed for correction of these deficiencies. In 1981 the Office of Professional Medical Conduct reorganized into its present form. New funding came from increased licensing fees paid by physicians which permitted a larger staff to meet mounting work loads. However, there were still procedural problems, including protracted delays due to difficulties in sched-

uling hearings with five-member panels. In November 1984 a conference at the Academy, held under the auspices of the Committee on Medicine in Society,[5,6] considered reforms in the process. Representatives from the New York State Department of Health, the Office of Professional Medical Conduct, the Board of Regents, the New York State and County Medical Societies, and members of the State Legislature attended. One result was the increase in funding from increased licensing fees. Some procedural changes were made, but the bifurcated system that divided authority between the Departments of Education and Health remained. Probation supervision of physicians was taken from the Department of Education and assigned to the Office of Professional Medical Conduct in 1986.

This study examines, for the first time, data from 1982 through 1989 to determine whether the current system both protects the public and assures fairness to those accused of misconduct. It must conclude that the structure and functioning of the process as they now exist are seriously deficient in these areas and that major reforms are urgently needed.

THE STRUCTURE

Several units are involved in the disciplinary system.

The Board of Regents. This body was created in 1784 under the name of the University of the State of New York to promote education, to visit and to inspect its institutions and departments, to distribute to or to expand or to administer for them such property and funds as the state may appropriate. Their number is four more than the existing judicial districts of the state and not fewer than 15. Seven year membership terms are staggered, and each member is elected by the state legislature by concurrent resolution. Currently, there are 17 lay members and one physician.

The Board of Regents has the final authority in the medical disciplinary process, subject only to review by the courts on appeal by the respondent physician. It has the licensing and disciplinary authority over 31 professional groups, including medicine, acupuncture, social work, massage, dentistry, occupational therapy, pharmacy, nursing and dental hygiene, to name a few of those related to the health professions. It functions within the State Department of Education. Members of the Board and the Commissioner of Education may be sued in the state courts by a respondent physician for cause, but they are immune from personal liability.

Commissioner of Health. In the medical disciplinary process, the Commissioner is charged with the appointment of the personnel of the Board for and Office of Professional Medical Conduct. In addition, he is an active participant in that he reviews records and decisions of hearing panels and has the

authority to approve or to modify penalties they recommend. He may remand cases to hearing panels for further consideration and may approve or deny recommendations of investigative panels for summary suspension of a physician's license to practice. Further, he may continue or deny this suspension should the hearing panel recommend such action beyond the legal period of 90 days or should the hearing require more time. At any point in the disciplinary process he may be sued in state courts by the respondent physician, but is immune from personal liability. The Commissioner appoints a physician to serve as his executive secretary, whose responsibilities in the disciplinary process are designated by the Commissioner. The structure and functioning of the disciplinary agency within the Department of Health are stated in statutes cited in the Appendix.

Board for Professional Medical Conduct. This board was created in the Department of Health in 1975 when the disciplinary process for physicians was transferred from the Department of Education, and consists of approximately 170 physicians and lay people. Physician members are appointed by the Commissioner of Health on recommendations of the Medical Society of the State of New York, the New York Academy of Medicine, the New York Osteopathic Society, the several County Medical Societies, any major organization of physicians licensed to practice in this State, and the Hospital Association of New York State. Lay members are also appointed by the Commissioner with the approval of the Governor. Membership on the Board is limited to three years, but reappointment may be made. Each year the Commissioner designates the chairman and vice-chairman of the Board. The Board chairman appoints committees of two physicians and one layman to act as investigative and hearing panels and violations committees.

Office of Professional Medical Conduct. This is the investigative arm of the process. It has a director and assistant director, appointed by the Commissioner, and investigates all complaints received through a corps of trained investigators, guided by consulting physician medical coordinators. After cases have been investigated they may be dismissed or submitted to an investigative or screening panel for its recommendations, which may include dismissal, administrative warning, referral to a violations committee, or to a hearing panel. The investigative panel may also recommend summary suspension in cases of imminent danger to the public from physicians' behavior.

Legal Section. The General Counsel of the Department of Health is the head of the division. This unit is part of the Division of Legal Affairs of the Department of Health. The Chief Counsel of the Office of Professional Medical Conduct supervises the lawyers and assisting staff in the unit. Cases are prosecuted by this section before the hearing committees. The prosecuting

lawyer also appears before the Regents Review Committee when cases are heard by that body, prior to their referral to the Committee on the Professions and finally to the Board of Regents.

Responses to court appeals by respondent physicians against decisions by the Commissioner of Health are prepared by the legal staff of the Department of Health and argued by lawyers from the Office of the State Attorney General. Suits brought against the Commissioner of Education by respondent physicians are dealt with by the legal department of the Department of Education and argued by lawyers from the Office of the state Attorney General.

Lawyers function as law judges. One sits with each hearing panel and rules on points of law, but may not question witnesses or vote in panel decisions. At the conclusion of a hearing, the panel determines "the findings of fact" and the law judge prepares the document which is reviewed by the hearing panel and is the basis for its disciplinary decisions. Law judges are appointed by the General Counsel of the Department of Health. They may serve as full-time civil servants or part-time attorneys in private practice, and are supervised by a Chief law judge.

THE PROCESS: "THE TWELVE STEPS"

The progression of a complaint from its receipt to the final disciplinary decision of the Regents may be divided into twelve steps.

1) Oral and written complaints are acted upon. These are received in the Albany office of the Office of Professional Medical Conduct and reviewed. Complaints that seem to lack merit or that deal with fee disputes are eliminated. Those outside the jurisdiction of the agency are referred to the appropriate one. The complainant is always informed of the action taken on his complaint by the office. Preliminary investigations are often made at this time. Complaints considered for further investigation are referred to the local office of the Office of Professional Medical Conduct that serves the area in which the alleged misconduct occurred.

2) In the local office a second screening is done by a medical coordinator, a board certified physician with many years of clinical practice. Some cases may be recommended for dismissal at this level, but if the complaint is considered meritorious, the medical coordinator assigns priority for investigation based upon the perceived gravity of the misconduct.

3) A medical coordinator and investigator are assigned to each case. Confidentiality is preserved. Appropriate certified copies of office or hospital patient records are sought to establish the facts in the case. Sometimes the

physician and the hospital cooperate with the investigation, but at other times subpoena power is needed to obtain records. The investigation may last weeks or months, depending upon complaint, cooperation by concerned parties, and current work load. Once investigation is completed, the respondent physician is invited for an interview. He may bring his lawyer.

4) The informal interview is conducted by the medical coordinator to permit the physician to "tell his side of the story." This interview is most advantageous to the respondent physician as well as to the medical coordinator in evaluation of the complaint. In many instances, following the interview dismissal is recommended. Sometimes the physician refuses to be interviewed. He is then notified that the case will be pursued without interview.

5) Should the evidence warrant, the case is referred to an outside consultant, board certified and experienced in the respondent physician's practice area. Such consultants are drawn from leading hospitals and medical schools. In metropolitan New York the County Medical Society has provided lists of physicians who have volunteered for this important service. These are paid $100/hour for time spent in this activity and $250/session should their testimony be required at the hearing. All care is exercised to assure that the physician in question is unknown to the consultant. Findings of the investigation and opinions of the investigator and medical coordinator are not disclosed to the consultant. An investigator hand-delivers only the certified patient records to the consultant, together with an accompanying letter in which the medical coordinator asks questions whether the practice patterns accord with acceptable medical standards or whether culpable deviations have occurred. He is asked to note specific deviations if they have occurred and to estimate their gravity. He does not deal with penalties. When the consultant's written report is ready, it and the records are collected by an investigator and returned to the Office of Professional Medical Conduct. He may conclude that no deviations from acceptable medical standards were found and the complaint may then be dismissed. On the other hand, the consultant's review may contain sufficient evidence of misconduct to warrant presentation to an investigative panel.

6) The investigative panel is drawn from the Board for Professional Medical Conduct, and consists of two physicians and one layman. Meetings are closed. Others present at this meeting are the chief counsel of the legal section and the director or assistant director of the Office of Professional Medical Conduct. Legal questions are discussed by the chief counsel. The entire record, including complaint, results of the investigation, and opinions of the

medical coordinator and consultant, and patient records are presented. At this point recommendation for dismissal may be made, and if so, the case is closed. However, the panel may refer the case to a violations committee, or an administrative warning may be sent to the physician. It is customary for any case in which a patient death has occurred to be presented to an investigative panel, whether or not the death is deemed a consequence of any physician misconduct. An administrative warning is not incorporated in the physician's permanent record. A medical coordinator gives the warning in writing or in person. The violations committee, composed of two physicians and one layman, hears cases of lesser misconduct, including minor technical violations. It may recommend such lesser disciplinary action as censure and reprimand, which enters the respondent's permanent record. The investigative panel may decide that additional information is required and further investigation will follow. The panel is empowered to authorize a "comprehensive medical review" which involves record-gathering from the physician's office to help to define his patterns of practice, and may subpoena office or hospital records if compliance has been refused.

7) If the investigative panel recommends a hearing, a lawyer from the legal staff prosecutes the case. Subsequently, charges are drawn and sent to the respondent. He is notified of a hearing date no later than 35 days after the statement of charges has been served. Adequate time will have elapsed to prepare his defense. The hearing panel is drawn from the Board for Professional Medical Conduct, two physicians and one layman. Periodically a list of projected hearings is circulated to all members of the Board, noting names of respondent physicians, cities where hearings are planned, and whether a particular specialist physician member is needed. Board members then indicate their availability to serve on panels, and these questionnaires are returned to the Office of Professional Medical Conduct. This process assures that respondent physicians are not known to Board members available to serve on specific panels, and provides that a specialist peer may be a member of the hearing panel. An administrative law judge sits at each hearing. Only panel members and lawyers may question witnesses; a court stenographer is present at all hearings and prepares transcripts; and all witnesses testify under oath. One of the three panel members, designated by the director of the Office of Professional Medical Conduct when the panel was constituted, presides. The hearing is conducted according to the rules of procedure and evidence used in administrative law.

The prosecuting lawyer for the Department of Health states the charges, previously given to the respondent physician. Evidence against the respondent is presented by the state's witnesses. The outside consultant, who has

previously reviewed the case, testifies. When the prosecutor's case is completed, the defense presents its case. Of 65 cases concluded by hearing panels in 1988, 49 required up to seven hearing days. However, there were 16 others that had eight to 21 hearing days. During 1989, 34 of 56 cases concluded had up to seven hearing days, but 22 others had eight to 38 hearing days! (Table 1) There is no limit to the number of hearing days or to the time they may span. At the conclusion of the hearing, the panel determines the "findings of fact," and the law judge prepares a panel report. This is reviewed in executive session by the panel, after which a disciplinary decision is made. Two panel members must agree to establish decisions. Guilt is based upon "the preponderance of evidence."

There is the special situation of a physician whose practice pattern constitutes an imminent danger to the public. In such cases the investigative panel may recommend summary suspension of the physician's license. Evidence is then presented to the Commissioner of Health, who may order that the physician cease to practise for 90 days from the date of the order. Within 10 days after the order, the Board for Professional Medical Conduct schedules the first of weekly hearings before a hearing panel. When the hearing is completed, the panel makes its recommendations to the Commissioner of Health with regard to penalties. On the issue of imminent danger, the panel decides whether the summary order should be left in effect or be modified. Within 10 days of notification, the Commissioner decides whether to retain or to modify the summary order. If the hearing panel has recommended that the summary order be maintained and 90 days have elapsed, the Commissioner may extend the summary order indefinitely until the decision by the Regents has been issued. On the other hand, the panel may suspend the summary order at any time during the hearing process with the approval of the Commissioner, and the hearing continues to its conclusion. The respondent may resume practice at the time of such action. In 1989 only two such suspensions were sustained by the Commissioner.

8) Following the conclusion of the hearing, the panel's disciplinary recommendations and the entire case record are sent to the Commissioner of Health who reviews the material and may modify the panel's recommendations. He may remand the case for further consideration by the hearing panel. Within 30 days he sends the record and his recommendations for disciplinary action to the Board of Regents, which designates its Review Committee to consider the record.

9) The group consists of one Regent and two others selected by the Board of Regents. They are assumed to have read the entire record. They hold a brief hearing, attended by the respondent, his lawyer, oftentimes new defense

TABLE I. HEARING DAYS 1984–1989

Year concluded	*Number concluded in year*	*Hearing days to conclusion*					*Number of hearing days*
		0–3	*4–7*	*8–11*	*12–15*	*16+*	
1984	56	45	5	4	1	1	27
1985	33	19	11	—	—	3	25, 29, 45
1986	36	19	10	4	1	2	33, 41
*1987	42	16	12	5	3	6	16, 17, 17, 18, 21, 29
*1988	65	25	24	7	4	5	17, 18, 19, 19, 21
*1989	56	18	16	9	5	8	38, 38, 17, 22, 19, 16, 20, 27

*Number of hearing days of cases started in 1984, 1987, 1988, and 1989 still in hearing as of January 1, 1990
1984—17
1987—8, 11, 12, 14, 20, 31
1988—9, 10, 10, 11, 14, 18, 20, 23
1989—5, 8, 8, 8, 9, 9, 10, 11, 12, 13

witnesses, and the lawyer from the Office of Professional Medical Conduct. This procedure may last about one hour. Except in cases of direct referral, no record is kept of the proceedings and no testimony is under oath. Formal rules of conduct do not operate and the meeting is closed. At the same sitting, the Review Committee may consider many other cases of alleged misconduct, some pertaining to physicians and some to other professions under the Regents' licensure jurisdiction. The Regents' Review Committee recommends disciplinary action. It may agree with or modify recommendations of the hearing panel and the Commissioner of Health.

10) It transmits its decisions to the Committee on the Professions. This body is composed of three Regents. They review the decisions of the Review Committee of the Regents. Their closed deliberations are not recorded, and may agree with or modify the decisions of the Review Committee.

11) After their review, the case is presented to the full Board of Regents as part of a session devoted to adjudicating complaints involving many other professions. No record is kept of their closed deliberations. Their decisions, which should be forthcoming within 60 days, may not come for one year or longer. They may remand the case for further deliberation by the hearing panel. They may agree with, reduce, or increase the disciplinary action by the hearing panel and the Commissioner. On rare occasions they may modify the decision of their own Review Committee. Final decisions of the Regents are made without explanation.

12) The last review may be obtained by judicial review before the Appellate Division, Third Department, the State of New York, and is based solely upon the record.

Except for the costs involved in his legal defense and the appeal to the Court, which are borne by the respondent physician, all other costs are paid by the Department of Health through the Office of Professional Medical Conduct and by the Department of Education through the Regents. The average cost for a hearing day, for the Department of Health, is about $2,000 for hearing panel, stenotypist, and the hearing record. All other costs for the investigation and the legal services are extra. Each hearing date represents considerable taxpayer and respondent physician expense. Everyone involved in the disciplinary process, save for the respondent physician, is immune from personal liability.

COMPLAINTS

There was a small decline in the numbers of complaints received by the Office of Professional Medical Conduct in 1989. (Table II) There were 3,806

TABLE II. INVESTIGATIVE CASE LOAD BY YEAR

	1982	*1983*	*1984*	*1985*	*1986*	*1987*	*1988*	*1989*
Number of cases on hand as of January 1	1,111	1,425	1,073	1,268	1,667	1,279	1,328	1,470
Number of cases opened during the year	670	819	1,525	1,699	2,352	3,429	4,076	3,806
Number of cases completed during the year	356	1,171	1,330	1,300	2,740	3,380	3,394	3,759

new complaints; 1,470 were on hand at the beginning of the year, making the total to be considered 5,276. Of these, 3,759 were processed and their investigations were completed during 1989. Ten percent were referred to other state agencies: 178 were referred for hearing and 81 for administrative warning. License surrender, temporary or permanent, occurred in 29 cases, and 10 monitoring agreements were made. The numbers are similar to those of the 1985–88 period.

Sources of complaints were similar during the three time periods, 1982–84, 1985–88, 1989. (Table III) More than three fourths came from the public and the Office of Health Systems Management. That agency has investigatory and regulatory responsibilities for hospitals and nursing homes respectively. State and county Medical Societies referred fewer than 1% of the complaints. The grievance committees of these organizations receive patient and physician complaints about their members. Hospitals review complaints concerning their staff physicians in their Quality Assurance Committees and they referred 3.6-6.1% of those received in the past nine years. Individual physicians accounted for 0.9-4.5%. Hospitals and physicians are required by law to report physician misconduct. Those who report physician misconduct are free from personal liability, and the Office of Professional Medical Conduct makes every effort to maintain the confidentiality of the source.

Direct referral. A category of cases that comprises some of the most serious examples of misconduct includes physicians licensed in New York State whose licenses in other states have been revoked, or who have been disciplined for misconduct that would warrant disciplinary action in New York, as well as those convicted of crimes in federal or state courts. Such misconduct includes Medicaid and Medicare fraud, forgery of documents, illegal possession of controlled substances and their prescription without

TABLE III. SOURCES OF COMPLAINTS

	1982–1984	*1985–1988*	*1989*
Medical societies	0.6%*	0.7%	0.4%
Physicians	4.5	0.9	1.8
Public	55.6	60.4	41.5
Hospitals	6.1	6.0	3.6
Office of Health Systems Management	5.9	21.5	36.9
Other state, federal, and county agencies	12.5	6.6	7.0
Health insurance companies	3.6	2.1	2.3
Professional review organizations	0.08	0.03	1.0
Out of state	2.5	3.4	1.2
Total number of cases	2,344	11,556	3,806

*Percentages of total complaints in each time period. All sources have not been included.

appropriate medical indication. These cases do not have panel hearings but are sent directly to the Commissioner of Health and then to the Board of Regents. During the four years 1985–1988, of the 657 cases which cleared the process 394 (60.0%) were by direct referral. In 1989 122 (55.2%) of the 221 cases were by direct referral.

Categories of misconduct. A total of 1,036 cases cleared the system from 1982 through 1989, but data available for this study during 1982 through 1984 did not include comment on the misconduct for which the physicians were reported to the agency and were judged by the Board of Regents. None of those 156 cases was dealt with by direct referral. Accordingly, the 657 cases processed from 1985 through 1988, and the 221 cases in 1989 for which the misconduct information was available, formed the basis for this part of the study. The statutory definitions of professional medical misconduct are listed in the Appendix.

These cases include misconduct due to involvement with drugs, physician impairment, substance abuse, mental and physical illness, fraud, negligence and incompetence, sexual abuse, and a miscellaneous group. These categories were based upon misconduct for which disciplinary decisions were made. More than one form of misconduct may have existed in some cases.

In estimating the frequency distributions of the several forms of misconduct, 657 cases were evaluated during 1985–88 and 221 cases during 1989. (Table IV) A striking finding was the reduction in the proportion of physicians involved in inappropriate or illegal prescription of controlled substances, their manufacture for distribution, or the outright sale of such substances as heroin and cocaine. This group constituted 40.4% of those referred for misconduct during 1985–88 and 19.5% during 1989. Small incre-

TABLE IV. CATEGORIES OF MISCONDUCT

	1985–1988	*1989*
Drug involvement	264 (40.2%)	43 (19.5%)
Drug/alcohol impairment	55 (8.4%)	22 (10.0%)
Mental/physical impairment	16 (2.4%)	9 (4.1%)
Fraud	154 (23.4%)	54 (24.4%)
Negligence/incompetence	96 (14.6%)	62 (28.1%)
Sexual abuse	44 (6.7%)	24 (10.9%)
Miscellaneous	28 (4.3%)	6 (2.7%)
Probation violation	0	1 (0.5%)
Total number of cases	657	221

ments were noted in the percentages of physicians impaired by substance abuse, 8.4% to 10.0% and in those impaired by mental and physical illness, 2.4% to 4.1%.

The frequency of fraud remained the same, 23% during 1985–88 and 24.4% during 1989. Frauds included overutilization of services and billing for services not rendered to Medicaid and Medicare patients, falsification of records, false representation of professional training and qualification, fraud in obtaining medical licensure, commercial health insurance fraud, false advertising, income tax evasion, and robbery. In many instances involving Medicaid fraud, criminal convictions had already been obtained in federal and state courts.

The problems of impaired physicians include substance abuse, e.g., alcohol and drugs, as well as mental and physical illness. The objectives in dealing with these physicians are rehabilitation through treatment and protection of the public by license surrender during the treatment period. License restoration may be achieved when treatment has been successful, with a period of monitoring for recidivism following license restoration.

There are two arms to this effort. The Department of Health funds a program, the Committee on Physicians' Health, administered by the Medical Society of the State of New York, and an Impaired Physicians' Program within the Office of Professional Medical Conduct. The larger number of physicians is referred to the Medical Society program. This process is confidential, not adversarial, and when a physician is reported, he is required to cooperate in appropriate pharmacological tests and psychological examinations. If suffering from substance abuse, the physician is referred to an inpatient treatment center, often situated out of state. Following treatment, the physician may undergo probation monitoring, with random urine testing,

for several years. If he resumes substance abuse, he may repeat the treatment process. If he refuses to cooperate with either treatment or probation monitoring, he is referred to the Office of Professional Medical Conduct for disciplinary action.

Fewer cases are reported to the Office of Professional Medical Conduct. Treatment programs designed by the Impaired Physician Program are individualized, and terms of surveillance after treatment are also planned with each physician. This program has dealt with 225 physicians since 1983: 102 physicians have cleared the program to date, and 15 of them have relapsed. The State Medical Society program has dealt with 485 physicians, and 232 are now under active surveillance. The recidivism rate is about 15%. It is interesting that 24% of physicians in the State Medical Society program were self-referred, 47.6% were colleague-referred, and only 4.3% were referred by hospitals. The Office of Professional Medical Conduct was responsible for 10.3% of referrals. These data were obtained as of June 1988.

In cases of mental impairment, effort is made to convince the physician to surrender his license voluntarily. This avoids the embarrassment, general unpleasantness, and costly legal fees of a hearing. Such efforts are not always successful, and the physician may be referred for disciplinary action through the hearing process.

The incidence of negligence and/or incompetence doubled from 14% in 1985–88 to 28.1% in 1989. Mental illness, improper prescription of controlled substances, fraud, and sexual abuse coexisted in some of these physicians. Negligence, incompetence, or both should alert one to look for other problems in physician misconduct. The incidence of sexual abuse increased from 6.3% to 10.4% during this time. This may represent a greater patient willingness to report such events. Many male physicians do not have a female nurse or other attendant present when a woman or girl is being examined. Such a witness could serve two purposes: protect an innocent physician against false accusations of sexual abuse and discourage a physician prone to such misconduct. In the case of the psychiatrist, the problem is more complex since the presence of a third person during interviews is not possible. Furthermore, patient transference and "acting out" may be more threatening. Careful note-taking by the physicians and prudent behavior can be protective to both parties. However, sexual affairs have occurred and difficulties often arise when the physician attempts to discontinue a relationship.

The miscellaneous group has included a wide range of misconduct such as patient physical abuse, failure to comply with reporting details, criminal possession of a weapon, assault upon a police officer, resisting arrest, man-

slaughter and receiving stolen property. The decline from 4.3% in 1985–88 to 2.7% in 1989 is probably insignificant and may represent differences in classification process.

COMMENT UPON DISCIPLINARY ACTIONS

The statutory penalties for professional misconduct are listed in the Appendix. During the first three years, 1982 through 1984, after the reorganization of the Office of Professional Medical Conduct, there was reasonably close agreement in the numbers of revocations recommended by the hearing panels, Commissioner, and Regents. This was particularly so with those of the latter two, 35.3% and 33.3% respectively. (Table VI) Except that the Regents reduced the overall penalties of the panel more often than did the Commissioner, there was general agreement between his recommendations and those of the Regents in 84.0% of cases. (Table V) During 1985 through 1988 there was a dramatic change. Overall agreement declined to 57.3% and Regents reduced the Commissioner's penalties in 39.5% of his recommendations. Regents also tended to reduce penalties recommended by panels during these later years. During 1989 the Board of Regents further reduced those penalties recommended by both the hearing panels and the Commissioner. One would have expected that increasing experience with this disciplinary responsibility would result in greater agreement.

One explanation forthcoming from the Regents is that due process was denied respondent physicians and therefore some correction of this deficiency in the process should be made by reducing penalties. This argument lacks merit. The numbers of hearing days which have been held (Table I) attest to the accommodations afforded to respondent physicians and their lawyers to plead their cases. Indeed, when hearings extend over periods of several years and upward of 25 hearing days are held, it can hardly be claimed that due process has been lacking. Finally, the right of the respondent physician to appeal to the courts is preserved.

During 1986 through 1989 60 physicians were convicted on criminal charges for Medicaid fraud. Most of these convictions were in federal court but some were in both federal and state courts. Sums of money involved ranged from $500 to more than $1,000,000. Most of the 60 cases were processed by direct referral. The Commissioner recommended revocation of license in 32 (53.3%) cases and the Regents in 20 (33.3%). Regents reduced the penalty recommended by the Commissioner in 34 (56.7%) of 60 cases. One physician was convicted of fraud in the amount of "$1,000,000 plus." Two convictions were obtained, one in federal and one in state court. The

TABLE V. AGREEMENT LEVELS OF PENALTIES RECOMMENDED BY HEARING PANELS, COMMISSIONER OF HEALTH, AND BOARD OF REGENTS

		Commissioner vs. Panel			*Regents vs. Panel*			*Regents vs. Commissioner*		
		=	*Reduce*	*Increase*	=	*Reduce*	*Increase*	=	*Reduce*	*Increase*
1982–84	No.	129	2	25	115	14	27	131	20	5
156		156	156	156	156	156	156	156	156	156
Cases	%	82.7	1.3	16.0	73.7	9.0	17.3	84.0	12.8	3.2
1985–88	No.	210	2	54	190	38	34	315	217	18
602		266	266	266	262	262	262	550	550	550
Cases	%	79.2	0.4	20.4	72.5	14.5	13.0	57.3	39.5	3.3
1989	No.	56	1	25	48	11	21	100	78	18
221		82	82	82	80	80	80	196	196	196
Cases	%	68.3	1.2	26.3	60.0	13.8	26.3	51.0	39.8	9.2

TABLE VI. REVOCATIONS RECOMMENDED BY HEARING PANELS, COMMISSIONER OF HEALTH AND BOARD OF REGENTS

		Hearing panels	*Commissioner of Health*	*Board of Regents*
1982–84	No.	46	55	52
		156	156	156
	%	29.5	35.3	33.3
1985–88	No.	81	232	165
		266	554	569
	%	30.5	41.9	29.0
1989	No.	17	67	54
		94	196	196
	%	18.1	34.2	27.6

Commissioner recommended revocation but the Regents reduced the penalty to suspension for five years, stayed the last four years, and required probation for four years. The terms of the probation required that the convicted physician come to the Office of Professional Medical Conduct every six months for examination of his billings. The Office has no personnel trained as auditors, and clearly such surveillance cannot be carried out.

There seems to have been little correlation between the amounts of money stolen and the severity of the final penalty ordered by the Regents. Sums of $25,000 to $100,000 did not result in a penalty of revocation in some instances; in others, licenses were revoked when sums as low as $1,400 and $2,300 were stolen.

During the same period of 1986 through 1989, 15 physicians were disqualified from participation in the Medicaid program after administrative hearings by the State Department of Social Services, and were referred to the Office of Professional Medical Conduct. Nine had been ordered by the department to make restitution in sums ranging from $561.20 to $75,000! Misconduct included substandard medical care, overutilization of tests and treatments, failure to keep adequate medical records, billing for services not rendered, and improper prescribing of controlled substances. Twelve (80%) cases were dealt with by direct referral. The Commissioner recommended revocation in four (26.7%) cases and the Regents in two (13.3%). In three cases the Commissioner recommended suspension for one to three years, stay and probation for like periods, whereas the Regents ordered dismissal of charges. In eight (53.3%) of the 15 cases, the Regents reduced the penalty.

Misconduct and third party payers. A recurring problem involves physicians whose charges for services are exorbitant and may represent gross

overutilization of tests or outright fraud. While the Office of Professional Medical Conduct is not involved in fee disputes as such, where inflated bills are generated by needless expensive blood tests and where double-billing is suspected, the issue of fraud is its proper concern. It is discouraging to see the large sums that some insurance carriers pay in such instances.

Third party payers should maintain better reporting contacts with the Office and refuse payment for such specious claims. Indeed, they should prosecute those responsible. Their investigative and legal resources are much greater than the Office's. One wonders how much payments of such inflated claims increase the insurance premiums charged by the companies. Excluding such physicians from the rosters of insurance companies might be more effective in stopping such practices than disciplinary penalties imposed by the Regents after months or years of expensive investigation and hearings.

Another area where such questionable practices have been seen is in auto accident "No Fault" cases. Prolonged visits to a physician lasting many months and charges for expensive electronic testings of questionable diagnostic value are examples of some abuses.

Perhaps the worst examples have been found in certain Medicaid practices by physicians. The abuses include overtesting, overprescribing, especially of controlled substances, catering to drug addicts, and providing grossly substandard medical care. Collusive practices by some physicians with pharmacies and laboratories are part of the problem. The Department of Social Services has uncovered these dishonest schemes, and their diligent efforts have led to criminal convictions in the cases discussed above.

Misconduct and patient encounters. Complaints often arise from physician communications with patients. Misunderstanding could be avoided if physicians assumed that many patients may not retain the information given them. Patient encounters with physicians are often intimidating, especially in hospital. Taking the time to review what has been said and to write down the diagnosis and the treatment program can obviate patient complaints and lawsuits. Situations involving patient impairment and lack of comprehension can be helped by the presence of a patient's friend or relative. There are other examples of actual or imagined patient abuse by physicians and their staffs. Patient complaints are that "he would not talk to me;" "a nurse gave me all the instructions and I never saw the doctor again;" "he was abrupt and impatient in his manner."

Failure of physicians to return telephone calls is another major complaint by patients. Sometimes this has resulted in grave consequences for patients. An additional source of needless conflict between patient and treating physician is a comment by a second physician derogatory of the first. It is not

uncommon for a patient to complain about a physician and to feel that the complaint was justified by another physician's comment.

PROBATION

Before 1986 the Department of Education monitored physicians placed upon probation as part of the disciplinary action. In 1986 this activity was assigned to the Office of Professional Medical Conduct. As of January 1989 159 physicians were in this category, a number fairly constant during the past two years.

Probation is the most frequent disciplinary action, and may extend for six months to 15 years. The final terms are determined by the Regents who may agree with or modify terms set by the hearing panel and the Commissioner of Health. Main issues are the appropriateness of the terms and their specificity because unless both aspects are dealt with properly, the entire purpose of the probation may be lost and public protection sacrificed. The previously cited example of the physician who was convicted of fraud in an amount exceeding $1,000,000 is noteworthy.

Another example of inappropriate terms of probation concerns a physician found guilty of gross negligence and incompetence by the hearing panel, the Commissioner of Health and the Regents' Review Committee. All three agreed on license revocation. This physician was treating cancer patients with self-styled "experimental" substances with no known anticancer effects, according to a designated spokesman of the National Cancer Institute, and he was without the usual investigational authorization by any legally authorized body. Nevertheless, the Committee on the Professions and the Board of Regents reversed these revocation recommendations without explanation. They imposed five years probation with the provision that he bring patient records for review by the Office of Professional Medical Conduct every three months and that he "not treat any patient with agents in violation of the law." Unfortunately, no statutes define such agents except as they may be in the laws governing the use of controlled substances. These substances were not at issue in this case. In effect this physician was authorized by the Board of Regents to continue the practice methods for which he was found guilty of gross negligence and incompetence by the hearing panel, the Commissioner of Health, and the Regents' Review Committee. No reasoned explanation for their reversal was forthcoming from the Board of Regents.

Several questions are germane to the issue of probation. Is the misconduct remediable, and are there reasonable ways to accomplish remediation? Are remediating programs available? Can the physician be monitored adequately

during the period of probation? Should the physician be permitted to practice while undergoing remediation?

Certain misconduct is so overwhelmingly egregious as to defy correction. In the case of a surgeon so inept technically or whose judgment is so flawed that grave patient harm results, it is in the public interest that his privilege to practice be revoked. Similarly, a physician whose ignorance and incompetence in patient care result in serious patient harm should have his license revoked. It is to those for whom probation may appear to provide an opportunity for remediation that our efforts should be directed. These distinctions may be very difficult to make. We have no documented experience upon which to base firm judgments; too brief a time has elapsed since probation became the responsibility of the Office of Professional Medical Conduct, and earlier useful data are not available.

There has been a tendency to rely upon continuing medical education courses to do the job of reeducation. For the most part, serious courses, particularly at medical schools and teaching hospitals, are designed to build upon a reasonable base of knowledge. Courses are relatively brief and are not designed to remedy the problems of physicians whose cognitive base or whose technical skills are inadequate.

Many physicians need much more than is provided by current continuing medical education courses. The words of Dr. Thomson in 1878[3] are relevant today. Current efforts to require recertification for medical licensure are noteworthy, especially for physicians who lack hospital affiliation. Some have little, if any, professional contact with other physicians or with professional meetings, conferences, and journals. Unfortunately, there are many such, particularly among those who practice in so-called "Medicaid Mills." Residencies are becoming fewer, and places where retraining residencies are provided are not readily available. The College of Physicians and Surgeons of Ontario has developed programs for physician-testing, assignment to programs of retraining and retesting thereafter, when physicians have been found to be deficient. This process has taken several years to develop and involves close cooperation with hospitals and medical schools. However, how should New York's public be protected from physicians during this retraining period?

There have been instances where terms of probation have included the physician's reporting on surgery done in his office, where specific practices have been forbidden. Monitoring office practice is extremely difficult and unreasonably time-consuming.

Sexual abuse poses a very difficult problem. Psychotherapy may help this condition. The requirement that a female nurse or attendant be present during

examination of female patients by a male doctor should be met. In the case of psychiatrists, this is not possible. To forestall accusations of pedophilia, a third person should be present during examinations. Repeated misconduct for sexual abuse should lead to license revocation.

A common misconduct is poor record-keeping. The College of Physicians and Surgeons of Ontario has developed programs for peer assessment of office practices. Its annual report for 1985 included reviews of 200 physicians. Care was considered acceptable in 98% of practices with good records. However, where poor records were found, deficient care came to almost 50%. Where inadequate care was observed, records were deficient in nearly 90% of the physicians examined.[7] Significant improvements have been achieved in this area during probation monitoring by the Office of Professional Medical Conduct. Illegible scrawls have given way to acceptable records including histories, physical examinations, and progress notes. The threat of further disciplinary action for persistently poor records eventually may have a salutory effect. It is surprising how many physicians do not consider good record-keeping a requirement for good practice.

There are many types of fraud. Cheating Medicaid, Medicare, and other third party insurers should be prosecuted vigorously by those respective agencies, and significant fines and restitution of funds should be required. Indeed, criminal conviction should call for license revocation. In other areas of fraud, such as falsification of records, misrepresentation of practice procedures or of curricula vitarum, meaningful fines may be an appropriate penalty. The use of a medical license to profit from the illicit prescription of controlled substances or from their outright sale should warrant revocation with heavy fines and imprisonment.

Finally, it would be well to track the success and failure of different probation terms to learn what succeeds and what fails. Only through such careful observation will the use of probation as a form of remediation become appropriate and fair to physicians and to the public. Violation of the terms of probation merits prompt disciplinary action by a hearing panel.

RESTORATION OF LICENSE

A physician may apply for license restoration one year after the revocation or surrender order becomes effective. A formal petition is addressed to the Board of Regents and sent to the Director, Division of Professional Licensing Services detailing the background of the case and why the physician wants to have his license restored. Supporting affidavits are required from at least five people who know the circumstances surrounding the loss of license and who

can testify to the character of the physician and his conduct since the license was lifted. A detailed account of the individual's activities during this period is required. The application is sent then to the Office of Professional Discipline of the State Department of Education for investigation. A copy is also sent to the Office of Professional Medical Conduct. After investigation, the applicant appears before a committee of his peers arranged by the Office of Professional Discipline. This committee sends its recommendations to the applicant and to the Director of the Division of Professional Licensing Services. The latter arranges for the applicant to appear before the Committee on the Professions. This group makes its recommendations and forwards its findings to the Board of Regents for final action. They may grant full restoration, conditional restoration with a stay of the revocation and a period of probation, denial of the restoration, and denial of reconsideration of the revocation. During the four years 1985–88, the Regents voted 165 revocations; two full restorations, five conditional restorations, four denials of restoration, and one denial of reconsideration of the terms of probation have been made.

CRITIQUE OF THE PROCESS

The bifurcated disciplinary process is needlessly long and does not adequately protect the public. The multiple hearing days, which may stretch on for years, tend to diminish the impact of the evidence, create a climate for legal wrangling, and divert attention from real issues. The claim by the Regents that due process has not been afforded the physician is without merit. It is more than adequately provided by the excessively long hearings and the many levels of review available to the physician. It is highly doubtful that any other administrative legal process would tolerate such a system.

The traditional role of the Board of Regents is an anachronism. Neither the Review Committee nor the full Board include significant medical expertise. Further, to expect the members of the Regents Review Committee, with their busy personal professional lives, to have read and digested thousands of pages of testimony is unreasonable. Brief retrial of cases under their special circumstances hardly constitutes fair review. Furthermore, their brief reports to the Committee on the Professions and to the full Board of Regents usually forms the basis for the final decision. Again, the disciplinary action is usually made without a written explanation. Finally, there are inordinate delays in the times required for the completion of the reviews and the disciplinary decisions by the Board of Regents. In 1987 and 1988 these times averaged 3.5 and 4.1 weeks, for the Commissioner of Health and 22.2 and 24.3 weeks for the

Board of Regents! The data for 1989 are not available at the time of manuscript preparation. During all this time, unless under summary suspension, the respondent physician continued to practice. This is fair neither to the public nor to the physician.

Failure by the Regents to appreciate the many problems in patient care and in medical education often result in inappropriate probation terms. Thus, the probation unit may be presented with decisions that are not only nonremediating, but that are unenforceable. Unfortunately, once probation terms are set by the Regents they cannot be changed by the probation unit.

There are problems within the Office of Professional Medical Conduct with regard to adequate staffing. The numbers of complaints, investigations, screening and hearing panel meetings have steadily increased, and added responsibilities for monitoring probationers have not been matched by appropriate increases in personnel. Serious bottlenecks interfere with the agency's ability to deal with the mounting work load.

The investigative staff is sorely tried, particularly in the New York City area. Assigning priority to complaint investigations by the medical coordinators helps to decide the order of case consideration, but this does not reduce the numbers of investigations. Structural changes are needed. The civil service system provides certain safeguards against hiring and promotion abuses, but interferes with the development of a permanent corps of experienced people who might be promoted on the basis of merit within the unit. Selection of personnel from lists, delays in giving examinations for higher level positions, and long waiting periods for appointment of new personnel for earned promotions combine to drive able people from the system to higher paying positions in other state agencies or to positions outside state service. A system based upon merit, with promotions within the agency, could prevent this loss of valuable personnel. This method operates in other state agencies.

On the legal side, lack of salary competitiveness with the private sector makes retention of experienced lawyers very difficult. More lawyers are needed to fill authorized places. The staff has been seriously reduced by resignations and leaves. Finally, the freeze on hiring during the recent state fiscal crisis has compounded the general problem of staffing.

A criticism has been levelled that the present functioning of the Board for and Office of Professional Medical Conduct in the disciplinary process is unfair to respondent physicians because persons within the State Department of Health investigate, litigate, judge, and make penalty decisions. So long as units are separated, this is accepted as how administrative disciplinary procedures. Indeed, the Board of Regents, in the Department of Education,

operates in the same manner with respect to the other 30 professions it licenses and disciplines. Further, the Board of Regents acts as the final disciplinary authority and not the Department of Health.

Frequent inconsistencies in penalty recommendations by the Board of Regents are unfair to some physicians and inadequately protect the public. The net effect is an inordinately slow system encumbered by a bifurcated process whose two arms often work at cross purposes. If the system is to provide the needed protection of the public, major changes must be made.

Disciplinary Processes in Other States, Ontario, and Great Britain

A review of the disciplinary process in 33 states reveals that only in New York is it so bifurcated and time-consuming. Elsewhere an independent agency, usually a Board of Medicine, has this function. The Board is composed of physicians and laymen. Physicians always comprise the majority, although the sizes of the Boards vary from state to state.

In Florida, Pennsylvania, and Arizona hearings are conducted by an administrative law judge. In other states the Board of Medicine or a designated member thereof conducts the hearing. The report of the hearing is reviewed by the Board and its judgment is final.

In the Province of Ontario the process is vested in the College of Physicians and Surgeons and a 27 member board is made up of 16 physicians elected by practicing physicians, the remainder designated by the academic community and provincial government. A Discipline Committee of five members hears the evidence and issues penalties. In Nebraska the Director of the Department of Health conducts the hearing and the Board of Medicine makes the final decision. In California a Board of Medical Quality Assurance, part of the Department of Consumer Affairs, supervises 14 statewide district committees. Three fifths of each committee are physicians. These committees hear cases and make final decisions, except where license suspension is for more than 30 days or where practice is limited for more than one year. In such cases a hearing is conducted by the Division of Medical Quality Assurance. Investigative and legal staffs assist in the process. In most states the entire process requires six to 12 months. In California and Iowa it may last longer in individual cases. In every state the decision may be appealed to appropriate courts.

In Great Britain the General Medical Council is responsible for medical education, licensing, and discipline. Its membership is apportioned from those elected by the 80,000 registered physicians, the universities, the Royal

Colleges, the Society of Apothecaries, and the Privy Council. In 1987–88 there were 967 complaints, and serious professional misconduct was attributed to 62 physicians. Fifteen required further investigation and 33 were referred for hearings. There are four levels of review, and both alcohol and drug abuse are serious problems.

PROPOSED CHANGES

New York's present system of medical discipline neither appropriately protects the public nor is consistently fair to respondent physicians. Tensions between the Departments of Health and Education (Board of Regents) have developed in recent years with regard to their respective roles and seriously interfere with the process. Both departments have heavy responsibilities, apart from the disciplining of physicians, one for the health and the other for the education of the people of New York. A shorter hearing time and a more consistent pattern of disciplinary penalties, while continuing to assure due process, would benefit both sides, and would free needed funds to relieve understaffing in the agency.

The Commissioner of Health and the Board of Regents should vacate their respective roles in deciding penalties. This would eliminate four steps from the current 12 step process and many months of delay in decision-making. The agency should remain in the Department of Health to provide some protection against outside pressures and to attract the professional consultative assistance so essential to the process. The budget of the agency should continue to come from physician licensing fees and fines from respondent physicians.

The Board for Professional Medical Conduct should remain the source of adjudicating panels. The Office of Professional Medical Conduct should continue to be the investigative body to deal with complaints, its legal section as prosecutors and its administrative law judge section as legal advisors to hearing panels. The authority of the Commissioner of Health to appoint the members and officers of both should continue. Organizations that currently propose members should continue to do so. A full-time physician executive secretary appointed by the Commissioner should assist the board and its committees. The board should appoint those committees required for its disciplinary process. Appointments in the other sections should continue to be made as is current practice.

The process should be rationalized to include one step each of trial and review, the first by a hearing panel of the Board for Professional Medical Conduct and the second by a panel from a newly designated review committee. This latter group, new to the process, should be drawn from board members with at least five years of active experience on investigative and

hearing panels. The initial size of this review committee should be 21: 14 physicians and seven laypeople. These numbers may increase should the work load warrant, and it might become necessary for some members to serve full time. Hearing and Review panels should have two physicians and one layperson, with the assistance of an administrative law judge. This latter group would review case records and statements submitted by opposing lawyers relating to the hearing panels' decisions. The Review panel would act as an appellate unit and would have authority to remand cases for further deliberation or to sustain or to modify the decision of the hearing panel. A two-thirds majority of the panel would be required for its decisions. It would issue its decision and penalty recommendations within 45 working days after receipt of the hearing records. The respondent physician should be notified of the decision by the Review panel within 10 working days after that panel has made its decision. Thereafter, appeal to the courts would continue to be available to the respondent physician. There should be a limit of 90 days after receipt of the decision of the Review panel for the physician to appeal. Prosecuting lawyers and the Office of the Attorney General would plan and conduct the defense as is currently the practice.

If summary suspension has been recommended by an investigative panel, a hearing panel should review the case and recommend for or against its implementation or continuation. Such a panel should be appointed whenever need arises. Summary suspensions now occur fewer than 10 times each year but should probably be much more frequent.

The structure and composition of the Office of Professional Medical Conduct and the appointment methods should be retained. Regional offices in New York City, Buffalo, Rochester, and Syracuse should continue. It should be possible to promote investigators for merit within the unit and to recruit them from outside the system.

The Probation Unit within the Office of Professional Medical Conduct should be strengthened. The large number of physicians on probation places a heavy burden on the two staff members. If probation recommendations are to constitute effective remediation, more knowledge must be gathered to validate what are now assumptions. This requires follow-up data to clarify the appropriateness and the effectiveness of terms of probation with the level of seriousness of the misconduct.

The legal section of the agency requires strengthening. It is now severely understaffed, and remuneration appropriate to the training and experience of the lawyers should be competitive with comparable legal agencies.

Continued support of the administrative law judges is essential to an effective hearing and review process. Here, too, adequate staff members are needed to expedite hearings. This group should continue to prepare the "find-

ings of fact'' document. The administrative law judge's role in the Review panel should be expanded. No disciplinary decisions should be issued without an explanation by the deciding body.

Parts of the current process should be retained. Steps 1 through 7 should continue, and current rules for conduct of hearings remain in place. At the initial meeting of a hearing panel, it should estimate the number of hearing days after consultation with opposing lawyers. Every effort should be made to be accommodative to all parties without permitting excessively long hearings. The hearing dates should be fixed as far in advance as possible. Changing a hearing date should be only for justifiable causes. Should one member of a panel become incapacitated and be unable to continue during a hearing, a replacement should be appointed from the Board for Professional Medical Conduct. This new member should review the transcript to date and sign a statement to that effect. Final disciplinary decisions in each case should be made public and reported to the Physician Disciplinary Data Bank of the Federation of State Medical Boards of the United States.

Currently cases of direct referral do not have panel hearings. Records relating to earlier convictions and a statement by a lawyer for the state are sent directly to the Commissioner, who usually recommends a penalty, and the Director of the Office of Professional Medical Conduct sends the entire record to the Board of Regents. It is proposed that such cases have just one level of review by a hearing panel from the Board for Professional Medical Conduct. Since evidence from prior convictions would be available to the panel, this would be a second hearing conducted in the format previously described for the Board's administrative hearings and should require a shorter hearing time. The Board's Review Committee would not be involved in these cases. As noted earlier, the direct referral cases comprised most of those processed during 1985–1989.

Provisions should be made to computerize the entire process. This would assist in tracking cases, the accumulation of data concerning time lags in the process, the forms of misconduct, and the penalties voted, including probation details. From such easily accessible data, deficiencies in the process could be readily identified and corrected. A much needed codification of types of misconduct and penalties could then be attempted to yield a better understanding of how to set terms of probation. While one cannot make such decisions with mathematical precision, there is room for improvement in the appropriateness of the final decisions now being made.

All members of the Board for Professional Medical Conduct should have continued training to be thoroughly acquainted with the system. Currently

each new member attends investigative and hearing panel sessions as an observer before serving. This should be continued and expanded with home study materials. Board members should be prepared to sit 12 or more days each year. All other professional personnel should be thoroughly familiarized with the entire disciplinary process.

Support staff must be adequate to the needs of the agency if it is to function effectively, and appropriate remuneration should be paid to all part-time and full-time personnel. Everyone involved in the disciplinary process should remain immune from personal liability, and the Attorney-General should be their legal protector.

Violation of probation should lead to prompt disciplinary action as is current practice.

Measures employed in dealing with impaired physicians should be continued. Temporary and permanent license surrender should be part of the process.

Provision should be made for disciplinary actions to be agreed upon by the agency's lawyer and the respondent physician's lawyer, with the approval of a designated three member committee from the board. An administrative law judge should sit with such a session to advise the panel on points of law. This could obviate many lengthy hearings, and would also reduce costs for the respondent physician and for the state.

A place has been made to discuss ethical issues in medicine in the curricula of medical schools. There should be a place for the discussion of medical misconduct, its forms, and the relevant regulations and disciplinary measures. Licensed house officers are not immune from disciplinary action, and far better that students and residents be aware of problems than that they become victims or violators. Attending physicians and administrative officers of hospitals should become familiar with this subject. Some medical schools are becoming increasingly concerned with student and resident substance abuse. Too often these abuses begin early in medical school or before, and their potential consequences should be dealt with as part of the education process. Hospitals should sponsor discussions of this important area with house officers, attending physicians, nurses, and supporting staffs.

An annual meeting should be held to include representatives of the Board for and Office of Professional Medical Conduct, legal section and administrative law judges as well as invited guests chosen by the officers of the board and the director and assistant director of the Office.

Finally, an Office of Public Information should be established. Appropriate questions from the public should be referred to that office for reply. It should disseminate relevant information to the public and to recognized med-

ical organizations. A staff adequate for its proper functioning should be appointed by the Board.

Experiences with some forms of misconduct has stressed the need for new regulations in the interest of public protection. Because of mounting concerns to reduce health care costs, physicians have been encouraged to engage in many surgical procedures in their offices, including abortions and plastic and cosmetic surgery. Such activities are generally unreported, and only when major mishaps are reported do the shortcomings of these practices come to light.

Abortions have been performed without adequate preoperative examinations, appropriate laboratory work, anesthesia back-up, appropriate monitoring and life-saving equipment and follow-up.

Death has sometimes resulted. Many non-fatal mishaps go unreported by patients, because of their fears concerning violation of their privacy. Plastic or cosmetic surgery has been performed by unqualified physicians with disastrous results. Physicians without hospital affiliation perform these procedures in their offices, with no supervision or reporting. While the profession is subject to increasingly burdensome regulations, good medical practice and public protection require that these activities be reportable to a state health agency.

LICENSING

Of 33 states examined in 1986, only in New York are licensing and final medical disciplinary action vested in a non-medical Department of Education. In all other states, a Board of Medicine or its equivalent exercises both functions. A licensing agency should be constituted to carry out this mission; both the licensing and disciplinary controls should be in one agency in the Department of Health. The periodic recredentialing of physicians in our state is currently under active study. This would require some reviewing process for physicians' competence to renew licenses at regular intervals. This trend is not unique to New York, and many specialty boards have moved in that direction. When recredentialing becomes a reality, it should also be under the authority of the licensing agency. Physicians should develop systems of physician surveillance; they know the problems of medical education, training, and patient care, and they should work together in these efforts.

The licensing of graduates of foreign medical schools should be reviewed. At this time there is urgent need for regular on-site investigation of the curricula and facilities at these schools. Some are in third world countries where standards are lower than those of American schools. Academic and

clinical preparation should not be taken on faith or accepted on the basis of the examination currently given, nor should the residency training required to fulfill licensing prerequisites be accepted on faith. Whereas some physicians train in well-supervised hospital teaching programs, some may not. If a residency is to be meaningful, it must be spent in appropriate approved programs. Periodic review should be required. Several years ago an unknown number of individuals fulfilled the requirements for licensure without having attended medical school by purchasing Caribbean medical degrees. How many of these imposters are still with us will never be known.

Recently many physicians have been referred to the Office of Professional Medical Conduct by the State Department of Social Services because of substandard medical care rendered under the Medicaid program, and were recommended for disqualification from participation in that program. Many were graduates of foreign medical schools. Review of their educational and training backgrounds and practice patterns revealed many with very serious inadequacies. Having passed certain examinations following the residency requirement, these physicians were duly licensed. This subject requires careful review and continued candid scrutiny. In a recent survey of nine low income communities 701 primary care physicians were in office practice: more than 70% were educated in Asian and Caribbean medical schools. 1.7 million people lived in those nine communities in New York City.[8]

SUMMARY

This review examines the current medical disciplinary process in New York State and assesses whether it protects the public and is fair to respondent physicians. Clearly there is urgent need for reform. Results of 1,036 disciplinary actions over the years 1982–1989 have been reviewed, with special attention to the 878 cases during 1985–89. The types of misconduct and their incidences among these physicians represent but a small segment of the more than 40,000 licensed practising physicians in this state. Extrapolations concerning their incidence should not be made from these limited data to the general population of physicians.

The many flaws in the present system have been noted. A brief review of the process in 32 other states, Ontario, and Great Britain has shown that New York's is the most cumbersome and lengthy. Changes are suggested to modify the present system preserving some features of the current process but eliminating others. Licensing and disciplinary processes should be included in a single agency within the Health Department and this must be kept independent.

Appendix

1) The statutes defining the organization of the Board of Regents, its structure and authorities are found in Sections 201, 202–204, 206, 210, Education Law and those defining the organization of the Office of Professional Medical Conduct are found in Section 230, Public Health Law of the State of New York. Definitions of Professional Misconduct are found in Section 5509 of the Education Law and in the regulations of the Board of Regents, 8NYCRR Sections 29.1, 29.2, and 29.4. The Penalties for Professional Misconduct are in Section 6511 of the Education Law.

2) Those statutes establishing the organization of the disciplinary body, the medical conduct proceedings and the role of the Commissioner of Health, within the process are in Section 230 of the Public Health Law. The surveillance of physicians on probation is included in this statute. Section 2803–2 deals with the reporting of professional misconduct.

Definitions of Professional Misconduct

Each of the following is professional misconduct, and any licensee found guilty of such misconduct under the definitions in Section 6510 shall be subject to the penalties prescribed in Section 6511:

1) Obtaining the license fraudulently

2) Practicing the profession fraudulently, beyond its authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion

3) Practicing the profession while the ability to practice is impaired by alcohol, drugs, physical disability, or mental disability

4) Being habitually drunk or being dependent on, or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects

5) A) Being convicted of committing an act constituting a crime under:
   (I) New York State Law or,
   (II) Federal Law or
   (III) The law of another jurisdiction in which, if committed within this State, would have constituted a crime under New York State Law;

   B) Having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York State, constitute professional misconduct under the laws of New York State

C) Having been found by the Commissioner of Health to be in violation of Article Thirty-three of the Public Health Law

6) Refusing to provide professional service to a person because of such person's race, creed, color, or national origin

7) Permitting, aiding, or abetting an unlicensed person to perform activities requiring a license

8) Practicing the profession while the license is suspended, or wilfully failing to register or notify the Department of any change of name or mailing address, or, if a professional service corporation wilfully failing to comply with Sections 1503 and 1514 of the Business Corporation Law

9) Committing unprofessional conduct, as defined by the Board of Regents in its rules or by the Commissioner in regulations approved by the Board of Regents

10) A willful violation by a licensed physician of subdivision eleven of Section 230 of the Public Health Law, or

11) A violation of Section 2803-D of the Public Health Law

PENALTIES FOR PROFESSIONAL MISCONDUCT

1) Censure and reprimand,

2) Suspension of license, a) wholly, for a fixed period of time; b) partially, until the licensee successfully completes a course of retraining in the area to which the suspension applies; c) wholly, until the licensee successfully completes a course of therapy or treatment prescribed by the Regents

3) Revocation of license

4) Annulment of license or registration

5) Limitation on registration or issuance of any further license

6) A fine not to exceed ten thousand dollars, upon each specification of charges of which the respondent is determined to be guilty

7) A requirement that a licensee pursue a course of education or training

8) A requirement that a licensee perform up to 100 hours of public service, in a manner and at a time and place directed by the Board. The Board of Regents may stay such penalties in whole or in part, may place the licensee on probation, and may restore a license which has been revoked. Any fine imposed pursuant to this section or pursuant to subdivision two of section 6510 of this article may be sued for and recovered in the name of the people of the State of New York, in any action brought by the Attorney General. In such action, the findings and determination of the Board of Regents or of the violations committee are admissible evidence and are conclusive proof of the violation and the penalty assessed.

ACKNOWLEDGMENTS

Thanks are due to the many whose generous cooperation has made this effort possible: Kathleen Tanner, Director; Laura Leeds, Assistant Director; Anne Bohenek, Public Health Aide; Chris Stern Hyman, Chief Counsel, O.P.M.C.; Susan Roberts, former Director of the License Restoration Committee, Department of Education; Dr. Allison Landolt, former Director, Committee on Physicians' Health, State Medical Society; Ellen Jensen, Director, Impaired Physicians' Program, O.P.M.C.; Lynn Hoback, former Head, Probation Unit; Cheryl Ratner, Probation Unit, O.P.M.C.; Wendy B. Cogger, Assistant Registrar, General Medical Council of the United Kingdom; Cynthia Taylor for her patience and diligence in the preparation of this manuscript; and Anne B. Post, for her patient editorial work. In addition, special thanks are due to Dr. Marvin Lieberman, Executive Secretary, Committee on Medicine in Society, the New York Academy of Medicine, for the many hours of discussion concerning this subject since 1975.

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